Published in final edited form as:

Psychosomatics. 2013 ; 54(6): 605–606. doi:10.1016/j.psym.2013.06.005.

Response—Suicide Screening in General Hospitals

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Ryan and Large¹ suggest that screening medically ill patients for suicide risk, described in Ask Suicide-Screening Questions to Everyone in Medical Settings: The asQ'em Quality Improvement Project,² “border[s] on the grotesque.” We disagree. Suicide is a rising international public health problem and medically ill patients, in particular, are at elevated risk.³ Suicidal thoughts and behaviors in these high-risk populations are under-detected and therefore under-treated. In our opinion, screening is far from “misguided.”

This project was judged by the National Institutes of Health’s Office of Human Subjects Research Protections as exempt from Institutional Review Board review because it was a quality improvement project implemented in response to the Joint Commission (JC) Sentinel Event Alert of 2010.⁴ Ryan and Large have conflated the JC’s 2010 Alert with the JC’s 2007 National Patient Safety Goal 15A.⁵ What is most notable about the more recent 2010 Alert is that the JC broadened the scope of this goal to include *all* patients who are at elevated risk, including the medically ill and those with no previously identified psychiatric symptoms, highlighting the JC data that reveal “many patients who kill themselves in general hospital inpatient units do not have a psychiatric history.”⁴ Twenty-five percent of the suicides that are reported to the JC occur in non-behavioral health settings, with 14% occurring on the medical inpatient unit. Because of these compelling data, the JC goes on to assert that “in order to effectively reduce the risk of suicide in the medical/surgical setting...organizations need to identify patients at risk of suicide and then intervene.”⁴

Suicidal ideation has been linked with future suicide attempts and death by suicide in adult medically ill populations, as referred to in citations 4–7 of the paper. We agree with Ryan and Large that a positive response to 1 of the 2 asQ'em items would not necessarily predict completed suicide; there are currently no screening instruments that can tell us who will and who will not kill themselves. Rather, a broader and more feasible goal of detecting suicidal thoughts on an inpatient medical unit is to identify otherwise occult suicidal thinking or

significant emotional distress and alert the medical care team that the patient may require further mental health evaluation.

Hospital gatekeepers, such as nurses, are well-positioned to expand the traditional medical evaluation to include a broader and more holistic biopsychosocial assessment. The asQ'em quality improvement project was developed to equip nurses with tools for rapid screening. Just as nurses routinely screen for falls risk and hypertension, universal screening for suicide expands the scope of a nursing assessment by uncovering potentially occult symptoms, thereby possibly minimizing morbidity and mortality associated with suicidal thoughts and behaviors.

Ryan and Large's notion that questions about suicidal thoughts are "disturbing questions" is stated without any data or justification. Our findings from this quality improvement project suggest quite the contrary. Importantly, 94% of patients reported that being screened for suicide was not burdensome. Most patients embraced the initiative, stating they were glad the hospital was asking these important questions. For Ryan and Large to suggest that health care professionals shy away from asking "deeply personal" questions of hospitalized patients runs counter to the tradition of medicine.

In closing, we believe the best way to identify patients at highest risk is to screen them. Recent studies examining death registries reveal that most patients who killed themselves visited a health care provider within just months before their death. These patients often present with somatic complaints and may not discuss suicidal thoughts unless asked directly. It remains unknown how many deaths could have been prevented if the clinicians had asked the patients if they had thoughts of suicide. Screening for suicide risk provides an opportunity for identification, prevention, and intervention. We believe these are compelling reasons to ask medical patients directly and routinely about suicide.

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